

MEDICAID QUESTIONNAIRE

NOTICE OF CONFIDENTIALITY

THE INFORMATION IN THIS DOCUMENT IS SUBJECT TO THE ATTORNEY-CLIENT PRIVILEGE, AS PROVIDED IN THE TEXAS RULES OF EVIDENCE.

THE CONTENTS OF THIS DOCUMENT CONSTITUTE ATTORNEY WORK PRODUCT.

THE CONTENTS OF THIS DOCUMENT ARE CONFIDENTIAL AND ARE NOT TO BE DISCLOSED TO THIRD PERSONS OTHER THAN THOSE TO WHOM DISCLOSURE IS MADE IN FURTHERANCE OF THE RENDITION OF PROFESSIONAL LEGAL SERVICES.

Name: _____
Last First Middle Maiden
Date of Birth: _____ Sex: _____ Social Security No. _____ - _____ - _____
Place of Birth: _____
Veteran: YES or NO
Living Arrangement:
_____ own home _____ apartment/rent house _____ household of another
_____ nursing home (entered _____) _____ assisted living/personal care home (entered _____)

Home Address – Street: _____
City: _____ State: _____ Zip code: _____
County: _____ Telephone No. (_____) _____

Mailing Address (if different): _____
City: _____ State: _____ Zip code: _____

Name of Spouse: _____
Last First Middle Maiden
Date of Birth: _____ Sex: _____ Social Security No. _____ - _____ - _____
Place of Birth: _____
Veteran: YES or NO
Date of Marriage: _____ Date of Death, if deceased: _____
Spouse's Living Arrangement:
_____ own home _____ apartment/rent house _____ household of another
_____ nursing home (entered _____) _____ assisted living/personal care home (entered _____)

Spouse's Home Address: _____
City: _____ State: _____ Zip code: _____

Do you have a legal guardian or Power of Attorney? Yes _____ No _____

Does your spouse have a legal guardian or Power of Attorney? Yes _____ No _____

Name of your Power of Attorney _____ Guardian _____

Your Power of Attorney's/Guardian's Address:

Your Power of Attorney's/Guardian's Telephone Number: (_____) _____

Name of spouse's Power of Attorney _____ Guardian _____

Spouse's Power of Attorney's/Guardian's Address:

Spouse's Power of Attorney's/Guardian's Telephone Number: (_____) _____

If no Power of Attorney or Guardian, Person Assisting with Financial and/or Personal Matters:

Address: _____

Telephone Number: (_____) _____

Do you have a Will? Yes _____ No _____

Does your spouse have a Will? Yes _____ No _____

Do you have a Medical Power of Attorney? Yes _____ No _____

Does your spouse have a Medical Power of Attorney? Yes _____ No _____

Do you have a Directive to Physicians: Yes _____ No _____

Does your spouse have a Directive to Physicians: Yes _____ No _____

Do you have a Declaration of Guardianship? Yes _____ No _____

Does your spouse have a Declaration of Guardianship? Yes _____ No _____

Do you have Medicare Part A? Yes _____ No _____

Do you have Medicare Part B? Yes _____ No _____

Does your spouse have Medicare Part A? Yes _____ No _____

Does your spouse have Medicare Part B? Yes _____ No _____

Health Insurance:	Company	Monthly Premium
Your Medicare Supplement:	_____	\$ _____
Spouse's Medicare Supplement:	_____	\$ _____
Your Prescription Plan:	_____	\$ _____
Spouse's Prescription Plan:	_____	\$ _____
Other:	_____	\$ _____
Other:	_____	\$ _____

Medical Condition:

Your Diagnosis: _____

Spouse's Diagnosis: _____

Resources: You and Your Spouse

Checking Accounts:	Account No.	Name of Institution	Amount

Savings Accounts:	Account No.	Name of Institution	Amount

Certificates of Deposit:	Account No.	Name of Institution	Amount

Money Market Certificates:	Account No.	Name of Institution	Amount

IRAs:	Account No.	Name of Institution	Amount

Retirement Accounts: (401(k), 403(b), etc.)	Account No.	Name of Institution	Amount

Investment Accounts, Annuities:	Account No.	Name of Institution	Amount

Savings Bonds: No. of Bonds Series Denomination Total Value

Certificated Stocks: No. of Shares Name of Company Total Value

Closed Accounts in Date Name of Institution Closing Balance
Last 60 Months:

Authorized Signer Owner of Funds Name of Institution Amount
on Other Accounts:

Safe Deposit Box Yes _____ No _____
Location:

Contents:

Patient Trust Fund Yes _____ No _____
at Nursing Facility:

Amount: _____

Cash on Hand: Amount: _____

Life Insurance: Policy Number Name of Company Face Value Cash Value

Burial Spaces: Name of Cemetery Number of Spaces Value

Preneed Funeral Name of Funeral Home Purchaser/Owner Value
Contract:

Does Someone Pay Date Name of Borrower Monthly Payment Balance
You a Promissory/
Mortgage Note:

Trusts, Partnerships, Date Name of Entity
Businesses, Other
Entities:

Automobiles, Trucks, Boats, Recreational Vehicles:	Year	Make	Model	Value
	_____	_____	_____	_____
	_____	_____	_____	_____

Homestead, including Mobile Home:	Address	Amount of Land	Value
	_____	_____	_____

Other Land, Lots, Houses (total or part ownership):	Address	Amount of Land	Value
	_____	_____	_____
	_____	_____	_____

Oil, Gas, Mineral, Surface Rights:	Description	Producing or Non-Producing	Value
	_____	_____	_____
	_____	_____	_____

Livestock, Poultry:	Description	Value
	_____	_____
	_____	_____

Work Equipment:	Description	Value
	_____	_____
	_____	_____

Ownership Interest in Anything Not Listed Above:	Description	Value
	_____	_____
	_____	_____

Have you transferred, deeded, sold, loaned, or given away any houses, lots, land, money, or anything else in the past 60 months? Yes _____ No _____

If Yes:	Date of Transaction	To Whom?	Market Value	Value Received
Item	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Income: You and Your Spouse

Social Security: Self:	Claim No.	Gross Monthly Amount
Spouse:	_____	_____
	_____	_____

Veterans Administration: Self:	Claim No.	Gross Monthly Amount
Spouse:	_____	_____
	_____	_____

Other Retirement: Description Gross Monthly Amount
Self: _____
Self: _____
Spouse: _____
Spouse: _____

Earnings: Description Gross Monthly Amount
Self: _____
Spouse: _____

Rental Income: Description Gross Monthly Amount
Self: _____
Spouse: _____

Oil, Gas,
Mineral Royalties: Description Gross Monthly Amount
Self: _____
Spouse: _____

Did anyone refer you? Yes _____ No _____ If yes, whom: _____